



February 2, 2007

HOUSE BILL No. 1572

DIGEST OF HB 1572 (Updated January 31, 2007 11:53 am - DI 97)

Citations Affected: IC 16-39; IC 27-1; IC 27-8; IC 36-8; noncode.

Synopsis: Various insurance matters. Provides that the department of insurance sets the amount charged for copies of medical records. Specifies requirements for assets in a segregated investment account for a funding agreement. Times preexisting condition provisions in an accident and sickness insurance policy from the effective date rather than the enrollment date. Amends various mandated benefit statutes defining "accident and sickness" policy to standardize the list of the types of policies that are not included in the use of the term. Makes various other amendments concerning accident and sickness insurance policies, travel accident policies, short term health policies, and long term care insurance producer compensation. Establishes an interim study committee to create a definition of "health insurance" for purposes of the law concerning accident and sickness insurance and health maintenance organization contracts.

Effective: July 1, 2007.

Fry, Ripley

January 23, 2007, read first time and referred to Committee on Insurance.
February 1, 2007, amended, reported — Do Pass.

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HB 1572—LS 7302/DI 97+



February 2, 2007

First Regular Session 115th General Assembly (2007)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2006 Regular Session of the General Assembly.

HOUSE BILL No. 1572

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 16-39-9-2 IS AMENDED TO READ AS
2 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. A provider may not
3 charge a person for making and providing copies of medical records an
4 amount greater than ~~provided in this chapter.~~ **the amount set in rules**
5 **adopted by the department of insurance under section 4 of this**
6 **chapter.**

7 SECTION 2. IC 16-39-9-4 IS AMENDED TO READ AS
8 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4. (a) As used in this
9 section, "department" refers to the department of insurance created by
10 IC 27-1-1-1.

11 (b) ~~Notwithstanding sections 1 and 2 of this chapter,~~ The
12 department may adopt rules under IC 4-22-2 to ~~adjust set~~ the amounts
13 that may be charged for copying records under this chapter. In adopting
14 rules under this section, the department shall consider the following
15 factors relating to the costs of copying medical records:

- 16 (1) The following labor costs:
17 (A) Verification of requests.

HB 1572—LS 7302/DI 97+



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- 1 (B) Logging requests.
 2 (C) Retrieval.
 3 (D) Copying.
 4 (E) Refiling.
 5 (2) Software costs for logging requests.
 6 (3) Expense costs for copying.
 7 (4) Capital costs for copying.
 8 (5) Billing and bad debt expenses.
 9 (6) Space costs.
- 10 SECTION 3. IC 27-1-12.7-10, AS AMENDED BY P.L.193-2006,
 11 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 12 JULY 1, 2007]: Sec. 10. Notwithstanding any other provision of law:
 13 (1) the commissioner has the sole authority to regulate the
 14 issuance and sale of funding agreements;
 15 (2) a funding agreement is not considered a covered policy under
 16 IC 27-8-8-1(a) or IC 27-8-8-2.3(d); ~~and~~
 17 (3) a claim for payments under a funding agreement must be
 18 treated as a loss claim described in Class 2 of IC 27-9-3-40; **and**
 19 **(4) assets supporting a funding agreement in a segregated**
 20 **asset account under section 8 of this chapter are subject to**
 21 **IC 27-9-3-40.5 and Class 1(c) of IC 27-1-5-1.**
- 22 SECTION 4. IC 27-8-5-2.5, AS AMENDED BY P.L.127-2006,
 23 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 24 JULY 1, 2007]: Sec. 2.5. (a) As used in this section, the term "policy
 25 of accident and sickness insurance" does not include the following:
 26 (1) Accident only, credit, dental, vision, Medicare supplement,
 27 long term care, or disability income insurance.
 28 (2) Coverage issued as a supplement to liability insurance.
 29 (3) Automobile medical payment insurance.
 30 (4) A specified disease policy. ~~issued as an individual policy.~~
 31 (5) A limited benefit health insurance policy. ~~issued as an~~
 32 ~~individual policy.~~
 33 (6) A short term insurance plan that:
 34 (A) may not be renewed; and
 35 (B) has a duration of not more than six (6) months.
 36 (7) A policy that provides a ~~stipulated daily, weekly, or monthly~~
 37 ~~payment to an insured during hospital confinement, without~~
 38 ~~regard to the actual expense of the confinement. indemnity~~
 39 **benefits not based on any expense incurred requirement,**
 40 **including a plan that provides coverage for:**
 41 **(A) hospital confinement, critical illness, or intensive care;**
 42 **or**

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(B) gaps for deductibles or copayments.

(8) Worker's compensation or similar insurance.

(9) A student health ~~insurance policy~~ **plan**.

(10) A supplemental plan that always pays in addition to other coverage.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

(b) The benefits provided by:

(1) an individual policy of accident and sickness insurance; or

(2) a certificate of coverage that is issued under a nonemployer based association group policy of accident and sickness insurance to an individual who is a resident of Indiana;

may not be excluded, limited, or denied for more than twelve (12) months after the effective date of the coverage because of a preexisting condition of the individual.

(c) An individual policy of accident and sickness insurance or a certificate of coverage described in subsection (b) may not define a preexisting condition, a rider, or an endorsement more restrictively than as:

(1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve (12) months immediately preceding the effective date of ~~enrollment~~ in the plan;

(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve (12) months immediately preceding the effective date of ~~enrollment~~ in the plan; or

(3) a pregnancy existing on the effective date of ~~enrollment~~ in the plan.

(d) An insurer shall reduce the period allowed for a preexisting condition exclusion described in subsection (b) by the amount of time the individual has continuously served under a preexisting condition clause for a policy of accident and sickness insurance issued under IC 27-8-15 if the individual applies for a policy under this chapter not more than thirty (30) days after coverage under a policy of accident and sickness insurance issued under IC 27-8-15 expires.

(e) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. Notwithstanding subsections (b) and (c), an individual policy of accident and sickness insurance may contain a

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waiver of coverage for a specified condition and complications directly related to the specified condition if:

(1) the period for which the exemption would be in effect does not exceed two (2) years; and

(2) all of the following conditions are met:

(A) The insurer provides to the applicant before issuance of the policy a written notice explaining the waiver of coverage for the specified condition and complications directly related to the specified condition, including a specific description of each condition, complication, service, and treatment for which coverage is being waived.

(B) The:

(i) offer of coverage; and

(ii) policy;

include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition and specifying each related condition, complication, service, and treatment for which coverage is waived.

(C) The:

(i) offer of coverage; and

(ii) policy;

do not include more than two (2) waivers per individual.

(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.

(E) The insurer agrees to:

(i) review the underwriting basis for the waiver upon request one (1) time per year; and

(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage and apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(G) The waiver of coverage does not apply to coverage required under state law.

(H) An insurance benefit card issued by the insurer to the applicant includes a telephone number for verification of coverage waived.

The insurer shall require an applicant to initial the written notice provided under subdivision (2)(A) and the waiver included in the offer

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of coverage and in the policy under subdivision (2)(B) to acknowledge acceptance of the waiver of coverage. An offer of coverage under a policy that includes a waiver under this subsection does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1. This subsection expires July 1, 2007.

(f) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. An insurer shall not, on the basis of a waiver contained in a policy as provided in subsection (e), deny coverage for any condition, complication, service, or treatment that is not specified as required in the:

(1) written notice under subsection (e)(2)(A); and

(2) offer of coverage and policy under subsection (e)(2)(B).

This subsection expires July 1, 2007.

(g) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. An individual who is covered under a policy that includes a waiver under subsection (e) may directly appeal a denial of coverage based on the waiver by filing a request for an external grievance review under IC 27-8-29 without pursuing a grievance under IC 27-8-28. This subsection expires July 1, 2007.

(h) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. Notwithstanding subsection (e), an individual policy of accident and sickness insurance may not contain a waiver of coverage for:

(1) a mental health condition; or

(2) a developmental disability.

This subsection expires July 1, 2007.

(i) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. A waiver under this section may be applied to a policy of accident and sickness insurance only at the time the policy is issued. This subsection expires July 1, 2007.

(j) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. An insurer or insurance producer shall not use this section to circumvent the guaranteed access and availability provisions of this chapter, IC 27-8-15, or the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191). This subsection expires July 1, 2007.

(k) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. A pattern or practice of violations of subsections (e) through (j) is an unfair method of competition or an unfair and deceptive act and practice in the business of insurance under IC 27-4-1-4. This subsection expires July 1, 2007.

SECTION 5. IC 27-8-5-15.6 IS AMENDED TO READ AS

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FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 15.6. (a) As used in this section, "coverage of services for a mental illness" includes the services defined under the policy of accident and sickness insurance. However, the term does not include services for the treatment of substance abuse or chemical dependency.

(b) This section applies to a policy of accident and sickness insurance that:

- (1) is issued on an individual basis or a group basis;
- (2) is issued, entered into, or renewed after December 31, 1999; and
- (3) is issued to an employer that employs more than fifty (50) full-time employees.

(c) This section does not apply to the following:

- ~~(1) An insurance policy listed under IC 27-8-15-9(b).~~
- ~~(2) (1) A legal business entity that has obtained an exemption under section 15.7 of this chapter.~~
- (2) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.**
- (3) Coverage issued as a supplement to liability insurance.**
- (4) Worker's compensation or similar insurance.**
- (5) Automobile medical payment insurance.**
- (6) A specified disease policy.**
- (7) A limited benefit health insurance policy.**
- (8) A short term insurance plan that:**
 - (A) may not be renewed; and**
 - (B) has a duration of not more than six (6) months.**
- (9) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:**
 - (A) hospital confinement, critical illness, or intensive care; or**
 - (B) gaps for deductibles or copayments.**
- (10) A supplemental plan that always pays in addition to other coverage.**
- (11) A student health plan.**
- (12) An employer sponsored health benefit plan that is:**
 - (A) provided to individuals who are eligible for Medicare; and**
 - (B) not marketed as, or held out to be, a Medicare supplement policy.**

(d) A group or individual insurance policy or agreement may not permit treatment limitations or financial requirements on the coverage

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of services for a mental illness if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(e) An insurer that issues a policy of accident and sickness insurance that provides coverage of services for the treatment of substance abuse and chemical dependency when the services are required in the treatment of a mental illness shall offer to provide the coverage without treatment limitations or financial requirements if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(f) This section does not require a group or individual insurance policy or agreement to offer mental health benefits.

(g) The benefits delivered under this section may be delivered under a managed care system.

SECTION 6. IC 27-8-5-19, AS AMENDED BY P.L.127-2006, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 19. (a) As used in this chapter, "late enrollee" has the meaning set forth in 26 U.S.C. 9801(b)(3).

(b) A policy of group accident and sickness insurance may not be issued to a group that has a legal situs in Indiana unless it contains in substance:

(1) the provisions described in subsection (c); or

(2) provisions that, in the opinion of the commissioner, are:

(A) more favorable to the persons insured; or

(B) at least as favorable to the persons insured and more favorable to the policyholder;

than the provisions set forth in subsection (c).

(c) The provisions referred to in subsection (b)(1) are as follows:

(1) A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the policy will continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period. A provision under this subdivision may provide that the insurer is not obligated to pay claims incurred during the grace period until the premium due is received.

(2) A provision that the validity of the policy may not be contested, except for nonpayment of premiums, after the policy

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has been in force for two (2) years after its date of issue, and that no statement made by a person covered under the policy relating to the person's insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless:

(A) the insurance has not been in force for a period of two (2) years or longer during the person's lifetime; or

(B) the statement is contained in a written instrument signed by the insured person.

However, a provision under this subdivision may not preclude the assertion at any time of defenses based upon a person's ineligibility for coverage under the policy or based upon other provisions in the policy.

(3) A provision that a copy of the application, if there is one, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are to be deemed representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the insured person or, in the event of death or incapacity of the insured person, to the insured person's beneficiary or personal representative.

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the person's coverage.

(5) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy and that is not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice, diagnosis, care, or treatment was received by the person or recommended to the person during the six (6) months before the ~~enrollment~~ **effective** date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of:

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- (i) the end of a continuous period of twelve (12) months beginning on or after the ~~enrollment~~ **effective** date of the person's coverage; or
- (ii) the end of a continuous period of eighteen (18) months beginning on the ~~enrollment~~ **effective** date of the person's coverage if the person is a late enrollee.

This subdivision applies only to group policies of accident and sickness insurance other than those described in section 2.5(a)(1) through 2.5(a)(8) and 2.5(b)(2) of this chapter.

(6) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice or treatment was received by the person during a period of three hundred sixty-five (365) days before the effective date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of the following:

(i) The end of a continuous period of three hundred sixty-five (365) days, beginning on or after the effective date of the person's coverage, during which the person did not receive medical advice or treatment in connection with the disease or physical condition.

(ii) The end of the two (2) year period beginning on the effective date of the person's coverage.

This subdivision applies only to group policies of accident and sickness insurance described in section 2.5(a)(1) through 2.5(a)(8) of this chapter.

(7) If premiums or benefits under the policy vary according to a person's age, a provision specifying an equitable adjustment of:

(A) premiums;

(B) benefits; or

(C) both premiums and benefits;

to be made if the age of a covered person has been misstated. A provision under this subdivision must contain a clear statement of the method of adjustment to be used.

(8) A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate, in electronic or paper form, setting forth a statement that:

(A) explains the insurance protection to which the person

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insured is entitled;

(B) indicates to whom the insurance benefits are payable; and

(C) explains any family member's or dependent's coverage under the policy.

The provision must specify that the certificate will be provided in paper form upon the request of the insured.

(9) A provision stating that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, but that a failure to give notice within the twenty (20) day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within that period and that notice was given as soon as was reasonably possible.

(10) A provision stating that:

(A) the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person making a claim, forms usually furnished by the insurer for filing proof of loss; and

(B) if the forms are not furnished within fifteen (15) days after the insurer received notice of a claim, the person making the claim will be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

(11) A provision stating that:

(A) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at reasonable intervals as may be required by the insurer;

(B) in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of the loss; and

(C) the failure to furnish proof within the time required under clause (A) or (B) does not invalidate or reduce any claim if it was not reasonably possible to furnish proof within that time, and if proof is furnished as soon as reasonably possible but (except in case of the absence of legal capacity of the claimant) no later than one (1) year from the time proof is otherwise required under the policy.

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1 (12) A provision that:

2 (A) all benefits payable under the policy (other than benefits
3 for loss of time) will be paid:

4 **(i) immediately upon receipt of written proof of loss if**
5 **the claim is filed by the policyholder; or**

6 **(ii) in accordance with IC 27-8-5.7 if the claim is filed by**
7 **the provider (as defined in IC 27-8-5.7-4; and**

8 (B) subject to due proof of loss, all accrued benefits under the
9 policy for loss of time will be paid not less frequently than
10 monthly during the continuance of the period for which the
11 insurer is liable, and any balance remaining unpaid at the
12 termination of the period for which the insurer is liable will be
13 paid as soon as possible after receipt of the proof of loss.

14 (13) A provision that benefits for loss of life of the person insured
15 are payable to the beneficiary designated by the person insured.
16 However, if the policy contains conditions pertaining to family
17 status, the beneficiary may be the family member specified by the
18 policy terms. In either case, payment of benefits for loss of life is
19 subject to the provisions of the policy if no designated or
20 specified beneficiary is living at the death of the person insured.
21 All other benefits of the policy are payable to the person insured.
22 The policy may also provide that if any benefit is payable to the
23 estate of a person or to a person who is a minor or otherwise not
24 competent to give a valid release, the insurer may pay the benefit,
25 up to an amount of five thousand dollars (\$5,000), to any relative
26 by blood or connection by marriage of the person who is deemed
27 by the insurer to be equitably entitled to the benefit.

28 (14) A provision that the insurer, **at the insurer's expense**, has
29 the right and must be allowed the opportunity to:

30 (A) examine the person of the individual for whom a claim is
31 made under the policy when and as often as the insurer
32 reasonably requires during the pendency of the claim; and

33 (B) conduct an autopsy in case of death if it is not prohibited
34 by law.

35 (15) A provision that no action at law or in equity may be brought
36 to recover on the policy less than sixty (60) days after proof of
37 loss is filed in accordance with the requirements of the policy and
38 that no action may be brought at all more than three (3) years after
39 the expiration of the time within which proof of loss is required
40 by the policy.

41 (16) In the case of a policy insuring debtors, a provision that the
42 insurer will furnish to the policyholder, for delivery to each debtor

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insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.

(17) If the policy provides that hospital or medical expense coverage of a dependent child of a group member terminates upon the child's attainment of the limiting age for dependent children set forth in the policy, a provision that the child's attainment of the limiting age does not terminate the hospital and medical coverage of the child while the child is:

(A) incapable of self-sustaining employment because of mental retardation or mental or physical disability; and

(B) chiefly dependent upon the group member for support and maintenance.

A provision under this subdivision may require that proof of the child's incapacity and dependency be furnished to the insurer by the group member within one hundred twenty (120) days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the two (2) years following the child's attainment of the limiting age. The policy may not require proof more than once per year in the time more than two (2) years after the child's attainment of the limiting age. This subdivision does not require an insurer to provide coverage to a mentally retarded or mentally or physically disabled child who does not satisfy the requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In any case, the terms of the policy apply with regard to the coverage or exclusion from coverage of the child.

(18) A provision that complies with the group portability and guaranteed renewability provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191).

(d) Subsection (c)(5), (c)(8), and (c)(13) do not apply to policies insuring the lives of debtors. The standard provisions required under section 3(a) of this chapter for individual accident and sickness insurance policies do not apply to group accident and sickness insurance policies.

(e) If any policy provision required under subsection (c) is in whole or in part inapplicable to or inconsistent with the coverage provided by an insurer under a particular form of policy, the insurer, with the approval of the commissioner, shall delete the provision from the policy or modify the provision in such a manner as to make it consistent with the coverage provided by the policy.

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(f) An insurer that issues a policy described in this section shall include in the insurer's enrollment materials information concerning the manner in which an individual insured under the policy may:

- (1) obtain a certificate described in subsection (c)(8); and
- (2) request the certificate in paper form.

SECTION 7. IC 27-8-5-20 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 20. (a) All individual accident and health insurance policies, other than those issued pursuant to direct response solicitation, must have a notice prominently printed on the first page of the policy stating in substance that the policyholder has the right to return the policy:

(1) except as provided in subdivision (2), within ten (10) days of its delivery; or

(2) if the policy is a travel accident insurance policy, until the earlier of:

(A) thirty (30) days after the policy is delivered; or

(B) the date of departure;

and to have the premium refunded if, after examination of the policy, the insured person is not satisfied for any reason.

(b) All accident and health insurance policies issued pursuant to a direct response solicitation must have a notice prominently printed on the first page stating in substance that the policyholder has the right to return the policy:

(1) except as provided in subdivision (2), within thirty (30) days of its delivery; or

(2) if the policy is a travel accident insurance policy, until the earlier of:

(A) thirty (30) days after the policy is delivered; or

(B) the date of departure;

and to have the premium refunded if, after examination of the policy, the insured person is not satisfied for any reason.

(c) Notwithstanding subsection (b), a short term health insurance policy that is written for a period of less than sixty-one (61) days and issued pursuant to a direct response solicitation must have a notice prominently printed on the first page stating in substance that the policyholder has the right to return the policy within ten (10) days of the policy's delivery and to have the premium refunded if, after examination of the policy, the insured person is not satisfied for any reason.

SECTION 8. IC 27-8-5-27 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 27. (a) As used in this section, "accident and sickness insurance policy" means an insurance

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policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis.

The term does not include the following:

(1) Accident only, credit, dental, vision, ~~Medicare~~, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy.

(5) A limited benefit health insurance policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides ~~a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.~~ **indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:**

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) Worker's compensation or similar insurance.

(9) A student health ~~insurance policy~~ **plan**.

(10) A supplemental plan that always pays in addition to other coverage.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

(b) As used in this section, "insured" means a child or an individual with a disability who is entitled to coverage under an accident and sickness insurance policy.

(c) As used in this section, "child" means an individual who is less than nineteen (19) years of age.

(d) As used in this section, "individual with a disability" means an individual:

(1) with a physical or mental impairment that substantially limits one (1) or more of the major life activities of the individual; and

(2) who:

(A) has a record of; or

(B) is regarded as;

having an impairment described in subdivision (1).

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(e) A policy of accident and sickness insurance must include coverage for anesthesia and hospital charges for dental care for an insured if the mental or physical condition of the insured requires dental treatment to be rendered in a hospital or an ambulatory outpatient surgical center. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the utilization standards for determining whether performing dental procedures necessary to treat the insured's condition under general anesthesia constitutes appropriate treatment.

(f) An insurer that issues a policy of accident and sickness insurance may:

(1) require prior authorization for hospitalization or treatment in an ambulatory outpatient surgical center for dental care procedures in the same manner that prior authorization is required for hospitalization or treatment of other covered medical conditions; and

(2) restrict coverage to include only procedures performed by a licensed dentist who has privileges at the hospital or ambulatory outpatient surgical center.

(g) This section does not apply to treatment rendered for temporal mandibular joint disorders (TMJ).

SECTION 9. IC 27-8-5.6-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. (a) As used in this chapter, the term "accident and sickness insurance" means any policy or contract covering one (1) or more of the kinds of insurance described in classes 1(b) or 2(a) of IC 1971, 27-1-5-1, as governed by IC 1971, 27-8-5.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A limited benefit health insurance policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care;

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or

(B) gaps for deductibles or copayments.

(9) A supplemental plan that always pays in addition to other coverage.

(10) A student health plan.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 10. IC 27-8-12-18 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 18. ~~(a) As used in this section, "compensation" includes pecuniary and nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including, but not limited to, the following:~~

~~(1) Bonuses;~~

~~(2) Gifts;~~

~~(3) Prizes;~~

~~(4) Awards;~~

~~(5) Finders fees.~~

~~(b) (a)~~ An insurer or other entity that provides a commission or other compensation to an insurance producer or other representative for the sale of a long term care insurance policy may not violate the following conditions:

(1) The amount of the first year commission or first year compensation for selling or servicing the policy may not exceed two hundred percent (200%) of the amount of the commission or other compensation paid in the second year.

(2) The amount of commission or other compensation provided in years after the second year must be equal to the amount provided in the second year.

(3) A commission or other compensation must be provided each year for at least five (5) years after the first year.

~~(c) (b)~~ If an existing long term care policy or certificate is replaced, the insurer or other entity that issues the replacement policy may not provide, and its insurance producer may not accept, compensation in an amount greater than the renewal compensation payable by the replacing insurer on renewal policies, unless the benefits of the replacement policy or certificate are clearly and substantially greater than the benefits under the replaced policy or certificate.

~~(d) (c)~~ This section does not apply to the following:

(1) Life insurance policies and certificates.

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(2) A policy or certificate that is sponsored by an employer for the benefit of:

(A) the employer's employees; or

(B) the employer's employees and their dependents.

SECTION 11. IC 27-8-14-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a); and

(2) is issued on a group basis.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A limited benefit health insurance policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(9) A supplemental plan that always pays in addition to other coverage.

(10) A student health plan.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 12. IC 27-8-14.1-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a); and

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(2) is issued on a group basis.

(b) As used in this chapter, "accident and sickness insurance policy" does not include **the following:**

- (1) ~~accident only;~~
- (2) ~~credit;~~
- (3) ~~dental;~~
- (4) ~~vision;~~
- (5) ~~Medicare supplement;~~
- (6) ~~long term care; or~~
- (7) ~~disability income;~~

~~insurance.~~

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A limited benefit health insurance policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(9) A supplemental plan that always pays in addition to other coverage.

(10) A student health plan.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 13. IC 27-8-14.2-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a).

(b) The term does not include the following:

- (1) Accident only, credit, dental, vision, Medicare supplement,

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long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy. ~~issued as an individual policy.~~

(6) A limited benefit health insurance policy. ~~issued as an individual policy.~~

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement; without regard to the actual expense of the confinement. **indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:**

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(9) A supplemental plan that always pays in addition to other coverage.

(10) A student health plan.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 14. IC 27-8-14.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. As used in this chapter, "health insurance plan" means any:

(1) hospital or medical expense incurred policy or certificate;

(2) hospital or medical service plan contract; or

(3) health maintenance organization subscriber contract;

provided to an insured.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy. ~~issued as an individual policy.~~

(6) A limited benefit health insurance policy. ~~issued as an individual policy.~~

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(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides ~~a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.~~ **indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:**

(A) **hospital confinement, critical illness, or intensive care; or**

(B) **gaps for deductibles or copayments.**

(9) **A supplemental plan that always pays in addition to other coverage.**

(10) **A student health plan.**

(11) **An employer sponsored health benefit plan that is:**

(A) **provided to individuals who are eligible for Medicare; and**

(B) **not marketed as, or held out to be, a Medicare supplement policy.**

SECTION 15. IC 27-8-14.7-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a); and

(2) is issued on a group basis.

(b) "Accident and sickness insurance policy" does not include ~~accident only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance.~~ **the following:**

(1) **Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.**

(2) **Coverage issued as a supplement to liability insurance.**

(3) **Worker's compensation or similar insurance.**

(4) **Automobile medical payment insurance.**

(5) **A specified disease policy.**

(6) **A limited benefit health insurance policy.**

(7) **A short term insurance plan that:**

(A) **may not be renewed; and**

(B) **has a duration of not more than six (6) months.**

(8) **A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:**

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- 1 **(A) hospital confinement, critical illness, or intensive care;**
 2 **or**
 3 **(B) gaps for deductibles or copayments.**
 4 **(9) A supplemental plan that always pays in addition to other**
 5 **coverage.**
 6 **(10) A student health plan.**
 7 **(11) An employer sponsored health benefit plan that is:**
 8 **(A) provided to individuals who are eligible for Medicare;**
 9 **and**
 10 **(B) not marketed as, or held out to be, a Medicare**
 11 **supplement policy.**
 12 SECTION 16. IC 27-8-14.8-1 IS AMENDED TO READ AS
 13 FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. (a) As used in this
 14 chapter, "accident and sickness insurance policy" means an insurance
 15 policy that:
 16 (1) provides at least one (1) of the types of insurance described in
 17 IC 27-1-5-1, Classes 1(b) and 2(a); and
 18 (2) is issued on a group basis.
 19 (b) "Accident and sickness insurance policy" does not include a
 20 policy providing accident only, credit, dental, vision, Medicare
 21 supplement, long-term care, or disability income insurance: the
 22 following:
 23 (1) Accident only, credit, dental, vision, Medicare supplement,
 24 long term care, or disability income insurance.
 25 (2) Coverage issued as a supplement to liability insurance.
 26 (3) Worker's compensation or similar insurance.
 27 (4) Automobile medical payment insurance.
 28 (5) A specified disease policy.
 29 (6) A limited benefit health insurance policy.
 30 (7) A short term insurance plan that:
 31 (A) may not be renewed; and
 32 (B) has a duration of not more than six (6) months.
 33 (8) A policy that provides indemnity benefits not based on any
 34 expense incurred requirement, including a plan that provides
 35 coverage for:
 36 (A) hospital confinement, critical illness, or intensive care;
 37 or
 38 (B) gaps for deductibles or copayments.
 39 (9) A supplemental plan that always pays in addition to other
 40 coverage.
 41 (10) A student health plan.
 42 (11) An employer sponsored health benefit plan that is:

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(A) provided to individuals who are eligible for Medicare;
and

(B) not marketed as, or held out to be, a Medicare
supplement policy.

SECTION 17. IC 27-8-24.1-1 IS AMENDED TO READ AS
FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. As used in this
chapter, "accident and sickness insurance policy" ~~has the meaning set~~
~~forth in IC 27-8-5-27(a).~~ means an insurance policy that provides at
least one (1) of the types of insurance described in IC 27-1-5-1,
Classes 1(b) and 2(a), and is issued on a group basis.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement,
long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A limited benefit health insurance policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides indemnity benefits not based on any
expense incurred requirement, including a plan that provides
coverage for:

(A) hospital confinement, critical illness, or intensive care;
or

(B) gaps for deductibles or copayments.

(9) A supplemental plan that always pays in addition to other
coverage.

(10) A student health plan.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare;
and

(B) not marketed as, or held out to be, a Medicare
supplement policy.

SECTION 18. IC 36-8-10-12 IS AMENDED TO READ AS
FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 12. (a) The department
and a trustee may establish and operate an actuarially sound pension
trust as a retirement plan for the exclusive benefit of the employee
beneficiaries. However, a department and a trustee may not establish
or modify a retirement plan after June 30, 1989, without the approval
of the county fiscal body which shall not reduce or diminish any

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benefits of the employee beneficiaries set forth in any retirement plan that was in effect on January 1, 1989.

(b) The normal retirement age may be earlier but not later than the age of seventy (70). However, the sheriff may retire an employee who is otherwise eligible for retirement if the board finds that the employee is not physically or mentally capable of performing the employee's duties.

(c) Joint contributions shall be made to the trust fund:

(1) either by:

(A) the department through a general appropriation provided to the department;

(B) a line item appropriation directly to the trust fund; or

(C) both; and

(2) by an employee beneficiary through authorized monthly deductions from the employee beneficiary's salary or wages.

However, the employer may pay all or a part of the contribution for the employee beneficiary.

Contributions through an appropriation are not required for plans established or modifications adopted after June 30, 1989, unless the establishment or modification is approved by the county fiscal body.

(d) For a county not having a consolidated city, the monthly deductions from an employee beneficiary's wages for the trust fund may not exceed six percent (6%) of the employee beneficiary's average monthly wages. For a county having a consolidated city, the monthly deductions from an employee beneficiary's wages for the trust fund may not exceed seven percent (7%) of the employee beneficiary's average monthly wages.

(e) The minimum annual contribution by the department must be sufficient, as determined by the pension engineers, to prevent deterioration in the actuarial status of the trust fund during that year. If the department fails to make minimum contributions for three (3) successive years, the pension trust terminates and the trust fund shall be liquidated.

(f) If during liquidation all expenses of the pension trust are paid, adequate provision must be made for continuing pension payments to retired persons. Each employee beneficiary is entitled to receive the net amount paid into the trust fund from the employee beneficiary's wages, and any remaining sum shall be equitably divided among employee beneficiaries in proportion to the net amount paid from their wages into the trust fund.

(g) If a person ceases to be an employee beneficiary because of death, disability, unemployment, retirement, or other reason, the

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1 person, the person's beneficiary, or the person's estate is entitled to
 2 receive at least the net amount paid into the trust fund from the person's
 3 wages, either in a lump sum or monthly installments not less than the
 4 person's pension amount.

5 (h) If an employee beneficiary is retired for old age, the employee
 6 beneficiary is entitled to receive a monthly income in the proper
 7 amount of the employee beneficiary's pension during the employee
 8 beneficiary's lifetime.

9 (i) To be entitled to the full amount of the employee beneficiary's
 10 pension classification, an employee beneficiary must have contributed
 11 at least twenty (20) years of service to the department before
 12 retirement. Otherwise, the employee beneficiary is entitled to receive
 13 a pension proportional to the length of the employee beneficiary's
 14 service.

15 (j) This subsection does not apply to a county that adopts an
 16 ordinance under section 12.1 of this chapter. For an employee
 17 beneficiary who retires before January 1, 1985, a monthly pension may
 18 not exceed by more than twenty dollars (\$20) one-half (1/2) the amount
 19 of the average monthly wage received during the highest paid five (5)
 20 years before retirement. However, in counties where the fiscal body
 21 approves the increases, the maximum monthly pension for an employee
 22 beneficiary who retires after December 31, 1984, may be increased by
 23 no more or no less than two percent (2%) of that average monthly wage
 24 for each year of service over twenty (20) years to a maximum of
 25 seventy-four percent (74%) of that average monthly wage plus twenty
 26 dollars (\$20). For the purposes of determining the amount of an
 27 increase in the maximum monthly pension approved by the fiscal body
 28 for an employee beneficiary who retires after December 31, 1984, the
 29 fiscal body may determine that the employee beneficiary's years of
 30 service include the years of service with the sheriff's department that
 31 occurred before the effective date of the pension trust. For an employee
 32 beneficiary who retires after June 30, 1996, the average monthly wage
 33 used to determine the employee beneficiary's pension benefits may not
 34 exceed the monthly minimum salary that a full-time prosecuting
 35 attorney was entitled to be paid by the state at the time the employee
 36 beneficiary retires.

37 (k) The trust fund may not be commingled with other funds, except
 38 as provided in this chapter, and may be invested only in accordance
 39 with statutes for investment of trust funds, including other investments
 40 that are specifically designated in the trust agreement.

41 (l) The trustee receives and holds as trustee all money paid to it as
 42 trustee by the department, the employee beneficiaries, or by other

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persons for the uses stated in the trust agreement.

(m) The trustee shall engage pension engineers to supervise and assist in the technical operation of the pension trust in order that there is no deterioration in the actuarial status of the plan.

(n) Within ninety (90) days after the close of each fiscal year, the trustee, with the aid of the pension engineers, shall prepare and file an annual report with the department. ~~and the state insurance department.~~
The report must include the following:

(1) Schedule 1. Receipts and disbursements.

(2) Schedule 2. Assets of the pension trust listing investments by book value and current market value as of the end of the fiscal year.

(3) Schedule 3. List of terminations, showing the cause and amount of refund.

(4) Schedule 4. The application of actuarially computed "reserve factors" to the payroll data properly classified for the purpose of computing the reserve liability of the trust fund as of the end of the fiscal year.

(5) Schedule 5. The application of actuarially computed "current liability factors" to the payroll data properly classified for the purpose of computing the liability of the trust fund as of the end of the fiscal year.

(o) No part of the corpus or income of the trust fund may be used or diverted to any purpose other than the exclusive benefit of the members and the beneficiaries of the members.

SECTION 19. IC 16-39-9-3 IS REPEALED [EFFECTIVE JULY 1, 2007].

SECTION 20. [EFFECTIVE JULY 1, 2007] (a) As used in this SECTION, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

(b) As used in this SECTION, "committee" refers to the interim study committee to define "health insurance" established by subsection (c).

(c) There is established the interim study committee to define "health insurance". The committee shall only study and make recommendations to the general assembly concerning the manner in which accident and sickness insurance policies, self-insured plans, and health maintenance organization contracts that provide coverage for health care services are defined in the Indiana Code.

(d) The committee consists of the following members:

(1) Four (4) members of the house of representatives, to be appointed by the speaker of the house of representatives, not

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- 1 more than two (2) of whom may represent the same political
- 2 party.
- 3 (2) Four (4) members of the senate, to be appointed by the
- 4 president pro tempore of the senate, not more than two (2) of
- 5 whom may represent the same political party.
- 6 (e) The committee shall operate under the policies governing
- 7 study committees adopted by the legislative council.
- 8 (f) The affirmative votes of a majority of the members
- 9 appointed to the committee are required for the committee to take
- 10 action on any measure, including final reports.
- 11 (g) The committee shall submit a final report to the legislative
- 12 council not later than October 31, 2007.
- 13 (h) This SECTION expires December 31, 2007.

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred House Bill 1572, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 6, delete lines 8 through 15, begin a new line block indented and insert:

- "(1) is issued on an individual basis or a group basis;
- (2) is issued, entered into, or renewed after December 31, 1999;
- and
- (3) is issued to an employer that employs more than fifty (50) full-time employees."

and when so amended that said bill do pass.

(Reference is to HB 1572 as introduced.)

FRY, Chair

Committee Vote: yeas 10, nays 0.

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